IMPLEMENTATION PLAN

EXPAND ACCESS TO CARE MANAGEMENT AND SUSTAINED FOLLOW-UP CARE FOR PERSONS AT RISK FOR SUICIDE

SELECTIVE GOAL 2

VA

U.S. Department of Veterans Affairs

Veterans Health Administration

Office of Mental Health and Suicide Prevention

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GOAL OVERVIEW

Expand access to care management and sustained follow-up care for persons at risk for suicide

LITERATURE REVIEW

INTRODUCTION

Current research on suicide prevention demonstrates the importance of expanding access to care management services and sustained follow-up care for individuals at risk for suicide. Primary care centers and emergency departments (EDs) are critical touchpoints for suicide prevention efforts; however, the fragmented health system creates significant barriers to effective patient care [1-4]. Care management has been shown to be effective in reducing some of these barriers by ensuring coordination of services and consistent follow-up care for patients [4, 5]. This review describes the need for, and the basis of, implementing a care management model within healthcare centers to increase protective factors for suicide.

RATIONALE

Physical healthcare locations such as primary care offices and EDs are critical touchpoints for suicide prevention and follow-up care for individuals at risk for suicide. Approximately half of those who die by suicide were seen by a provider in the year prior to their death, and individuals with self-injury or who attempted suicide are often brought to the ED for treatment [6]. Yet, most individuals who are treated for intentional self-harm in the ED do not receive a psychiatric or follow-up assessment [7]. The transition from an outpatient or inpatient setting to the home is a crucial period for suicide risk, with a significant proportion of suicide deaths occurring within the first month after discharge [8]. Physical healthcare providers are often undertrained in identifying suicide risk signs and the proper methods for encouraging individuals at risk for suicide to pursue treatment or support. In addition to implementing and training providers on universal screening protocols such as the Columbia Suicide Severity Rating Scale (C-SSRS), instituting care management and follow-up practices within physical health sites to follow up with patients identified as at risk for suicide can increase patient engagement with treatment.

THE CARE MANAGEMENT MODEL

Care management can support the identification and treatment of individuals in physical health settings who are at risk for suicide. Care management seeks to improve patient care and reduce the need for emergency medical services by enhancing coordination of care, eliminating duplication of efforts, and helping patients and providers more effectively manage complex and comorbid health conditions [5]. Care management can also reduce some of the barriers that patients may face in accessing and utilizing care through improved patient-provider communication and helping patients navigate the health system.

Care management can reduce suicide risk and increase the likelihood that patients will attend mental health treatment by consulting with providers to identify and treat mental health issues and following up with patients to monitor their status [4, 9]. Care management programs typically involve specially trained nurse care managers who communicate with providers and meet in-person or on the telephone with patients on a regular basis to screen for suicide risk, develop and update a safety plan for the patient, and consult with or refer to a psychiatric specialist as needed [10]. Using patient-centered care to develop a safety plan can provide the patient with effective coping strategies, while consistently following up with the patient after the office or hospital visit can provide the patient with support and increase treatment engagement [8].

The implementation of care management typically includes provider education, monitoring of patients and follow-up contact by care managers, and warm hand-offs between healthcare providers. Provider education involves training healthcare providers on the structure and role of an integrated care management system, educating providers on the mental health conditions that can increase risk of suicide, and training providers on the use of the

Columbia Suicide Severity Rating Scale (C-SSRS) to identify individuals at risk for suicide and refer them to treatment. Care managers are responsible for monitoring patient care, coordinating care, and consistently following up with patients to ensure that patients are connected to the proper care, are engaging in treatment, and have a social support system in place. Lastly, effective care management includes the use of warm hand-off protocols across the health system to ensure continuity of care between referring providers.

EFFECTIVENESS OF CARE MANAGEMENT

Research has shown that care management is effective in reducing suicide risk. One study on follow-up care management for depression patients in primary care found that those receiving follow-up had a higher probability of receiving medication, had a 50% improvement in depression scores, and had a lower probability of major depression diagnostic criteria at three- and six-month follow-up evaluations compared to those receiving treatment as usual [11].

The effectiveness of care management on mental healthcare outcomes was also investigated in the IMPACT study. In this study, older adults with depression were provided access to a depression care manager for twelve months. The care manager offered education, problem-solving skills, antidepressant management, and psychotherapy to patients as needed. They found that compared to usual care, care management improved rates of depression treatment, increased patient satisfaction with depression care, lowered depression severity, reduced functional impairment, and improved the patient's quality of life [12].

A third study on care management was the GRACE study. In this study, an advanced practice nurse and a social worker collaborated with primary care physicians and geriatricians to provide patient-centered care to low-income seniors. The care management team collaborated with the patient to develop and implement a care plan for the patient, while the nurse and social worker conducted face-to-face visits (primarily in-home) or telephone contact with the patient. They found that, compared to treatment as usual, patients receiving care management had significant improvements at the 24-month follow-up in four of the eight health outcome measures: general health, vitality, social functioning, and mental health. The cumulative two-year ED visit rate was also lower for patients receiving care management [13].

PAYMENT AND SUSTAINABILITY OF CARE MANAGEMENT

While the effectiveness of care management for chronic diseases and mental health disorders has been established, care management payment systems have yet to be optimized. Because care management often requires a team of diverse providers and specialists, payment for these services can be complicated. Care management services are not covered by all insurance providers, and most fee-for-service payment models do not reimburse medical practices for care management services. The Centers for Medicare and Medicaid Services (CMS) implemented a new billing code for chronic care management, but Medicaid coverage of care management still varies by state and Medicare only covers chronic care management services if the patient has at least two chronic conditions that are expected to last at least one year [14, 15]. While targeted case management is an optional Medicaid benefit that states can elect to cover, the services are only covered for specific beneficiary groups based on medical condition or geographic region [16].

In addition to coverage of care management services, the sustainability of care management programs is also crucial to ensure that patients continue to have access to these programs. Sustainability involves determining how, and ensuring that, the program will be maintained in the future. This includes funding for the program and/or payment for program services; resources and staff required to run the program; training for providers to continually improve knowledge and proficiency; continual maintenance of provider-provider and patient-provider

communication channels; and continual program evaluation and quality improvement efforts. Sustainability is an ongoing process that should be adaptable to changing patient and health system needs.

CONCLUSION

This literature review illustrates the necessity of expanding access to care management and sustained follow-up care for individuals at risk for suicide. Care management can improve patient care and reduce the need for emergency medical services by enhancing care coordination, improving the patient-provider relationship, and helping patients and providers more effectively manage complex and comorbid health conditions. The care management model has been shown to be effective in improving treatment engagement and reducing symptoms of mental health disorders and can serve as a crucial liaison in the healthcare system for suicide prevention efforts. The following sections outline steps to implement expanded care management and follow-up care for individuals at risk for suicide within VISN 23.

REFERENCES

1. Frandsen, B.R., et al., *Care fragmentation, quality, and costs among chronically ill patients.* The American journal of managed care, 2015. **21**(5): p. 355-362.
2. Miller, I.W., et al., *Suicide Prevention in an Emergency Department Population: The ED-SAFE Study.* JAMA Psychiatry, 2017. **74**(6): p. 563-570.
3. Ting, S.A., Sullivan, A. F., Boudreaux, E., Miller, I., & Camargo, C. A. , *Trends in US emergency department visits for attempted suicide and self-inflicted injury, 1993–2008.* General Hospital Psychiatry, 2012. **34**(5): p. 557-565.
4. Benjamin G. Druss, M.D., M.P.H. ,, et al., *A Randomized Trial of Medical Care Management for Community Mental Health Settings: The Primary Care Access, Referral, and Evaluation (PCARE) Study.* American Journal of Psychiatry, 2010. **167**(2): p. 151-159.
5. Rosenthal, T.C., *The Medical Home: Growing Evidence to Support a New Approach to Primary Care.* The Journal of the American Board of Family Medicine, 2008. **21**(5): p. 427-440.
6. Schulberg, H.C., et al., *Preventing suicide in primary care patients: the primary care physician's role.* General Hospital Psychiatry, 2004. **26**(5): p. 337-345.
7. Olfson, M., Marcus, S. C., & Bridge, J. A., , *Emergency Treatment of Deliberate Self-harm.* Archives of General Psychiatry, 2012. **69**(1): p. 80-88.
8. Matarazzo, B.B., et al., *Connecting Veterans at Risk for Suicide to Care Through the HOME Program.* Suicide and Life-Threatening Behavior, 2017. **47**(6): p. 709-717.
9. Stanley, B., et al., *Brief Intervention and Follow-Up for Suicidal Patients With Repeat Emergency Department Visits Enhances Treatment Engagement.* American Journal of Public Health, 2015. **105**(8): p. 1570-1572.
10. Nutting, P.A., et al., *Improving Detection of Suicidal Ideation Among Depressed Patients in Primary Care.* The Annals of Family Medicine, 2005. **3**(6): p. 529-536.
11. Simon, G.E., et al., *Randomised trial of monitoring, feedback, and management of care by telephone to improve treatment of depression in primary care.* BMJ, 2000. **320**(7234): p. 550-554.
12. Unützer, J., et al., *Collaborative Care Management of Late-Life Depression in the Primary Care SettingA Randomized Controlled Trial.* JAMA, 2002. **288**(22): p. 2836-2845.
13. Counsell, S.R., et al., *Geriatric Care Management for Low-Income SeniorsA Randomized Controlled Trial.* JAMA, 2007. **298**(22): p. 2623-2633.
14. Agency for Healthcare Research and Quality, *Care Management: Implications for Medcial Practice, Health Policy, and Health Services Research*, U.S.D.o.H.a.H. Services, Editor. 2018 Agency for Healthcare Research and Quality: Rockville, MD. .

15. U.S. Centers for Medicare and Medicaid. *Chronic care management services*. Available from: https://www.medicare.gov/coverage/chronic-care-management-services.
16. Bachrach, D., Guyer, J., & Levin, A. , *Medicaid Coverage of Social Interventions: A Road Map for States* 2016.
17. Spear, S.B., H. K., *Decoding the DNA of the Toyota production system.* Harvard Business Review, 1999. **77**(5): p. 96-106.

ACTION STEPS

1. By Month 2 of implementation, develop talking points for communicating to physical healthcare providers the importance of patient access to care management and sustained follow-up.

2. By Month 3 of implementation, develop a compendium of local, state, and federal resources that can be used to guide physical healthcare providers to support care management and follow-up care practices with their patients.

3. By Month 3 of implementation, develop template program guidelines for physical healthcare provider organizations to use to pledge that their organizations will implement care management and follow-up care practices (including hiring a specified care manager, if needed).

4. By Month 6 of implementation, develop training materials to train healthcare organizations (and hired care managers, if appropriate) on care management and follow-up practices.

5. By Month 6 of implementation, develop personalized protocols to guide organizations on how to implement care management and follow-up practices.

6. By Month 6 of implementation, identify as many physical healthcare organizations as possible and obtain pledges.

7. By Month 12 of implementation, provide the following for organizations that pledge to implement care management and follow-up practices:

    - Training for organizational leadership and an identified site Champion;
    - Personalized implementation protocols;
    - Ancillary resources;
    - Staff training (via virtual webinars when necessary);
    - Technical assistance (as funding permits); and
    - Monitored quality improvement and progress assistance.

8. By Month 18 of implementation (Year 1) and subsequent years, achieve penetration rates as defined in Tables 1 and 2.

METRICS

1. 100% of steps in the implementation protocol are implemented as planned.

2. 100% of participants achieve sufficient knowledge of how to implement care management and sustained follow-up care for individuals at risk of suicide.

3. 80% of healthcare organizations continue implementing care management and sustained follow-up care after the initial training and implementation period.

4. 100% of patients identified as being at risk for suicide receive care management services and sustained follow-up care services.

5. 80% of patients identified as needing suicide risk services or treatment obtain the appropriate level of treatment.

6. Achieve the penetration benchmarks for Year 1, Year 2, Year 3, and Year 4 based on Tables 1 and 2 below.

Table 1. Penetration Rates for Rural Areas Years 1–4

# of Eligible Sites in Catchment Area	Target % of Intervention Sites Per Year (Years 1–4)			
	Year 1	Year 2	Year 3	Year 4
1	100%	100%	100%	100%
2	50%	100%	100%	100%
3	33%	67%	100%	100%
4	25%	50%	75%	100%
5	20%	40%	60%	80%
6	16%	33%	50%	66%

Table 2. Penetration Rates for Urban Areas Years 1–4

# of Eligible Sites in Catchment Area	Target % of Intervention Sites Per Year			
	Year 1	Year 2	Year 3	Year 4
5–7	30%/40%	50%/60%	70%/80%	90%/100%
8–10	20%/30%	40%/50%	60%/70%	80%/90%
10+	10%	20%	30%	> 30%

IMPLEMENTATION TIPS[1]

Associated Action Step Component	Implementation Tip	PERU Support Provided
Systems Transformation Framework	Throughout the entire planning, implementation, and evaluation process, it is essential that you use all of the Systems Transformation Framework principles to support the optimal performance of your coalitions and implementation sites.	PERU has developed applications and resources as well as checklists that you can use on an ongoing basis to ensure that your coalitions and implementation sites are performing optimally.
Talking Points	When developing talking points or intervention/program marketing materials to help recruit participants in your intervention, ensure that the language and content of the materials are appropriate to the audiences and stakeholder groups involved. Talking points and materials aimed at healthcare providers will be different than talking points and materials aimed at community members, even if they are for the same intervention.	PERU will help review and craft talking points or marketing materials for interventions and programs.
Resource Development	When developing resources, access reputable literature and experts for information. It is also beneficial to ask stakeholders involved in the intervention's implementation sphere[2] what would be useful. This way, you can provide exactly what your collaborators need.	PERU will help to develop resources and can connect OESs with experts for developing materials.
Program Development	When developing program guidelines for intervention participants, tailor the guidelines to individual organizations. Guidelines should be in line with the training materials and implementation protocol expectations outlined for the intervention.	PERU will help review and craft program guidelines and pledges.
Training Development	Ensure that trainings sufficiently cover the knowledge points and skills that intervention participants need to know. Begin by outlining knowledge and skill objectives. You may also need to develop separate trainings for different stakeholders involved.	PERU will help to identify knowledge and skill targets as well as develop trainings and identify appropriate trainers.
Training Evaluation	When applying training, evaluate changes in knowledge pre- and post-training using a valid instrument.	PERU will assist in developing knowledge evaluations for intervention trainings.
Training Evaluation	When applying training that involves skill development, evaluate skill acquisition using a proficiency checklist. Separate proficiency checklists should be developed for separate skills within an intervention.	PERU will assist in developing proficiency checklists for intervention trainings.

[1] Some tips may not be relevant to every intervention.
[2] Implementation sphere is defined as the community and all of the relevant stakeholders/participants that are targeted and involved in some way (either passively or actively) in conducting the implementation.

Associated Action Step Component	Implementation Tip	PERU Support Provided
Implementation Fidelity	All protocols should incorporate the key components of the intervention needed for fidelity with the literature review. Key components can include: a. Specific instruments/documents used for the intervention; b. Information on who implements each step of the intervention and when the step is completed (e.g., who completes suicide risk screening and when? What happens when a person at risk is identified?); c. Steps for knowing how the step of the protocol has been implemented (i.e., feedback loops); and d. Steps for how implementation will be tracked (i.e., how progress will be recorded).	PERU will help review and develop implementation plans for each intervention.
Program Development	All protocols should be developed using the *Lean Rules in Use*.	PERU will provide assistance in ensuring that all protocols follow the *Rules in Use.*
Stakeholder Identification	When identifying participating organizations and sites, keep in mind that you want to begin with the site that has the greatest organizational health. Organizations with better organizational health will have better implementation success. You can then leverage this success in recruiting other sites. Once you have identified participating organizations, you will want to conduct an organizational health assessment to identify sites with strong organizational health.	PERU can help you with conducting the type of organizational health assessment that best suits your community and implementation sphere.
Communication Plan	Prior to beginning implementation, develop a communication plan that describes communication from: a. Coalition to coalition leadership; b. Coalition leadership to OES; c. Implementation site leadership to coalition; d. OES to facility/VISN leadership; and e. Any other stakeholders to any other stakeholders necessary. Communication plans should describe who will be responsible for the communication of updates, questions, and concerns; how communications will be transmitted; and how frequently communications should occur.	PERU can help to design communication plans with the coalition and intervention team that best address the target audiences.
Motivational Interviewing	When implementing interventions, use motivational interviewing when working with stakeholders in your implementation sphere to navigate challenges and barriers.	PERU can help OESs (and coalitions) learn how to apply POLAR*S, a scheme for motivational interviewing, to manage stakeholder relationships for different purposes.

Associated Action Step Component	Implementation Tip	PERU Support Provided
Evaluation Plan	When planning implementation, develop an evaluation plan to evaluate your intervention's progress and effectiveness. It is essential to use appropriate performance measures and benchmarks to effectively guide implementation.	PERU will work with you to strategize ways of collecting relevant performance measures and reporting measures and benchmarks to relevant stakeholders in your implementation sphere.
Real-Time Evaluation	When evaluating your interventions, performance measurement and benchmark reports should be issued in as close to real time as possible and used to address barriers and challenges.	PERU will help you evaluate these reports to identify strategies for improving implementation performance.

IMPLEMENTATION WORKSHEETS

Expand access to care management and sustained follow-up care for persons at risk for suicide

VISION WORKSHEET

The following will review how to create a Vision for your subcommittee and goal.

THE IDEAL VISION

Your Vision….

- Should capture the ideal future you want to achieve;
- It should be measurable so that you can collect data to see how far or close you are to achieving the Vision;
- It should be succinct and easy to remember;
- It should be something your whole subcommittee believes in; and
- Once agreed upon, the Vision should be communicated continuously on all program resources and presentations and during meetings.

VISION EXAMPLES

- Reduce overdoses to zero in Minnesota.
- Reduce suicides to zero in Loess Hills.
- Improve the health, safety, and well-being of all the individuals within the communities we serve.

BRAINSTORM

As a subcommittee, brainstorm some ideas for your Vision. What are some key words or ideas you want your Vision to cover? How will you make your Vision memorable?

Write (or type) these ideas in the space below.

CHOSEN VISION

Write (or type) your final crafted Vision below.

SUBCOMMITTEE ROLE SPECIFICATION WORKSHEET

Each subcommittee should have at least two types of members: one (1) or two (2) Leads and General Members. You also want to ensure your subcommittee has members represented from stakeholder groups that will help you accomplish your action items and goals. Use the following worksheet to identify subcommittee members and roles and responsibilities.

SUBCOMMITTEE MEMBERS

Use the following table to list your subcommittee members, affiliation, stakeholder group, and contact information. Use the next worksheet, Stakeholders Worksheet, to learn more about different stakeholder groups. You can continuously add to this list as your subcommittee expands or changes.

Name	Affiliation (Organization Name)	Stakeholder Group	Contact Information (Email/Phone)

ROLES AND RESPONSIBILITIES

Use the following table to define roles and responsibilities for subcommittee members. Identify two Leads and General Members. You are also welcome to identify your own roles (e.g., secretary, data manager, etc.) if desired in the blank rows provided. Be sure to define responsibilities for these other roles.

For subcommittee leads, an ideal lead will have the social capital and leverage to connect your subcommittee to needed resources and stakeholders. Ideal leads could be local government members, leaders/members of healthcare provider organizations and associations, and/or individuals with connections to training and resource expertise.

Name(s)	Role	Responsibilities
	Lead (Primary)	• Report out during subcommittee meetings. • Keep subcommittee focused during meetings. • Complete assigned action items. • Follow up with subcommittee members to ensure action items are completed between meetings.
	Lead (Secondary)	In absence of primary lead: • Report out during subcommittee meetings. • Keep subcommittee focused during meetings. • Complete assigned action items. • Follow up with subcommittee members to ensure action items are completed between meetings.
	General Members	• Have sufficient authority so they can complete assigned action items (e.g., send emails, set up training events, etc.). • Have appropriate content knowledge linked to the interventions or the institutions/organizations in which the interventions will be implemented. • Have evaluation expertise (if needed).
		•
		•
		•
		•
		•

STAKEHOLDERS WORKSHEET

The following worksheet will help your subcommittee identify and determine which stakeholder groups you want to involve in the implementation of your goal. These stakeholder groups, organizations, and individuals might be implementation sites where you want to implement the intervention/goal OR they might be organizations/persons who can provide resources and information that will help you accomplish your action items and goals.

INSTRUCTIONS FOR COMPLETING THE WORKSHEET

Stakeholder Group: This column lists the different stakeholder groups you may want to involve in the implementation of your goal. There are blank spaces if there are stakeholder groups not listed that you want to include.

Needed for Implementation?: Write or type 'yes' in the column and row if you want to involve the stakeholder group. Leave blank if you do not want to involve them.

Catchment Area Organization or Individual: List specific organizations or individuals within your catchment area that are part of these stakeholder groups. You might have multiple organizations/individuals for a group.

Reason for Involvement: Describe the reason for involving this specific stakeholder group as it pertains to the goal.

Stakeholder Group	Needed for Implementation?	Catchment Area Organization or Individual	Reason for Involvement
Veterans and Veteran Serving Organizations			
Law Enforcement			
Emergency Medical Services			
Suicide Survivors (e.g., direct, friends, family)			
Media Organizations			
Physical Health Providers			
Mental and Behavioral Health Providers			
Faith-Based Organizations			
Suicide Prevention Experts			
Public Figures			
Local Institutions and Employers			
Suicide Prevention Organizations			
Education Organizations (e.g., schools, universities)			
Program Evaluators (if not reflected by above)			

COMMUNICATION PLAN WORKSHEET

Once you have identified the stakeholders and individuals who will be involved (or be points of contact) in the implementation of your goal and intervention, you will want to develop a communication plan between your various partners. This communication plan should describe the frequency of communication and the format of the communication.

Use the following table to develop your communication plan.

INSTRUCTIONS FOR COMPLETING THE WORKSHEET

Purpose of Communication: Write or type what the communication will correspond (e.g., weekly update, etc.)

Sender: Write or type who will send the communication. This can be an organization but ideally a specified person will be identified to help maintain accountability.

Receiver: Write or type who will receive the communication. This can be an organization, but ideally a specified person will be identified to help maintain clarity.

Frequency: Write or type how frequently the communication will be sent (e.g., daily, weekly, monthly).

Format: Write or type how the communication will take place (e.g., conference call, in-person meeting, email).

Purpose of Communication	Sender	Receiver	Frequency	Format

IDENTIFYING AN APPROACH WORKSHEET

The literature review at the beginning of this implementation plan describes a number of different approaches or previous studies relevant to the goal. The goal of this worksheet is to determine the specific approach or method for accomplishing the goal. Determining the approach may involve relying on the expertise of your Outreach and Education Specialist and other subject matter experts.

DESCRIBE THE LITERATURE

Review the literature review and if needed, review the specific references and articles used in the literature review. Summarize all of the different approaches taken that are reviewed in the literature in the space below. Describe how these approaches are related. Your Outreach and Education Specialist can help you develop this review.

IDENTIFY A SUBJECT MATTER EXPERT

Identify a subject matter expert who can provide insight on the best approach for implementing the intervention or accomplishing the goal. Your Outreach and Education Specialist can help you identify a subject matter expert.

TOOLS AND RESOURCES

From the literature review or other sources, identify the evidence-based tools and resources you want to use. This might be a specific training program or a specific screening instrument or treatment method you want to implement. Your Outreach and Education Specialist can help you identify the evidence-based tools and resources you might need for this intervention.

IDENTIFY THE IMPLEMENTATION SITES

From the literature reviews, identify who is the target audience for your intervention (who will be applying the intervention directly with patients or community members). This may include community members, local healthcare providers, local businesses and organizations, firearm retailers, or others that are specific to your communities. Your Outreach and Education Specialist can help you determine your target audience.

ACTION STEPS AND PLAN-DO-STUDY-ACT WORKSHEETS

Now that you have laid the groundwork for operating your subcommittee, identified key stakeholders, and formulated a planned approach, you can now begin completing the Action Steps to achieve your goal. Think of Action Steps as the objectives for your goal. For the most part, you will complete these in sequential order or concurrently (a few Action Steps implemented at the same time). Plan-Do-Study-Act (PDSA) Cycle Worksheets will help you lay out and plan the specifics of your Action Step(s) as well as help you document your progress toward completing your Action Step(s). The following will present instructions for how to use the worksheets.

INSTRUCTIONS FOR COMPLETING THE WORKSHEET

An example PDSA worksheet has been provided below, followed by a template worksheet.

Each meeting, you will be provided a worksheet to record your action items your subcommittee plans to complete between meetings. The Outreach and Education Specialist will collect the worksheet at the end of each meeting, and then scan and email out the worksheet with other meeting minutes. At the following meeting, you will be given back the worksheet to document updates. Then, you will be provided a subsequent worksheet to repeat the process. If you are working on multiple Action Steps at a time, ensure you have the right number of worksheets.

Date/Next Meeting Date: Write the date of the current meeting. Write the date of when you will be meeting next.

Action Step (Circle One): Circle the number for the Action Step you are working on based on the order of the Action Steps list in this implementation plan.

Action Step: Write down when you want the Action Step completed based on the time points listed in the Action Steps section of this implementation plan.

PLAN

Tasks: In this column, list the tasks your subcommittee decides on during the meeting and plans to complete by the following meeting. They should be SMART: specific, measurable, achievable, relevant, and timely. Make sure your tasks are feasible to complete and will substantially make progress toward completing your Action Step.

Person Responsible: List who will be responsible for completing the Task.

Process Indicators: List out how you will know the Task was completed successfully. Process indicators are the direct products or deliverables that result from the Task. You should have process indicators for each Task.

Outcomes: List out the outcomes you hope to achieve with this Task. This might be a long-term outcome that is not directly related to the Task. Reference the metrics list with your goal's implementation plan to see which metric/outcome closely aligns with your Task.

Due Date: List when you want the Task completed. The due date can be the subsequent coalition meeting date.

DO

Now that you have your plan, use the worksheet to remind yourselves of what to accomplish between coalition meetings. The Subcommittee Lead should follow up with those listed as "Person Responsible" to ensure individuals are completing their assigned Tasks.

STUDY

Completed/Barriers/Successes: Review Tasks at the next meeting. Identify whether they were completed (yes/no). Discuss and record any barriers or challenges that arose in completing the Task.

ACT

Based on your review of your progress, barriers or challenges, and successes, grab a new worksheet and list out your NEXT Tasks. If you experienced challenges, your next Tasks might be actions your subcommittee wants to take to remedy the challenge/barrier. If the previous Task was successful, you will want to list the next Task that will further you in accomplishing your Action Step.

PLAN-DO-STUDY-ACT WORKSHEET EXAMPLE

Goal: Expand Access to Care Management and Sustained Follow-Up Care for Persons at Risk for Suicide

Date: 01/14/2020 **Next Meeting Date:** 02/11/2020

Action Step (Circle One): 1 2 3 4 5 6 7 8

Action Step End: Month 2

Tasks	Person Responsible	Success Looks Like:		Due Date	Completed/Barriers/Successes (next meeting)
		Process Indicators	Outcomes		
Outline talking points.	Dave Smith	Outlined talking points	Obtain buy in from organizations to participate in intervention.	02/11	Yes. Dave would like input from coalition leadership on outline.
Identify list of audience members for talking points.	Emily Burton	List of recognized organizations and contact information.	Obtain buy in from organizations to participate in intervention.	02/11	Yes. Emily feels the list is overwhelming though and would like to discuss narrowing down the number of organizations.

PLAN-DO-STUDY-ACT WORKSHEET

Goal: Expand Access to Care Management and Sustained Follow-Up Care for Persons at Risk for Suicide

Date: **Next Meeting Date:**

Action Step (Circle One): 1 2 3 4 5 6 7 8

Action Step End Date:

Tasks	Person Responsible	Success Looks Like:		Due Date	Completed/Barriers/Successes (next meeting)
		Process Indicators	Outcomes		

DATA COLLECTION WORKSHEET

Once you begin implementing your intervention and goal, you will want to collect data to help track your progress and effectiveness. The following worksheet will help you plan how you will collect the data needed to formulate the metrics listed for this implementation plan and goal. The following will describe the instructions for completing the Data Collection Worksheet.

INSTRUCTIONS FOR COMPLETING THE WORKSHEET

Metric: This column lists the metric from the metrics list featured at the beginning of this implementation plan. No action is required for this column.

Instrument Method: In this column, list the instrument or method you will use to collect the data needed for the metric. Your Outreach and Education Specialist can help you design a data collection instrument.

Collected From: In this column, list the stakeholders or individuals that you will be collecting the data from. In some cases, this may be your own subcommittee/coalition. Other times, it will be data you want to collect from implementation partners or directly from patients or community members.

Who Will Collect: In this column, list the individuals responsible for collecting the data. This may be a member of your subcommittee or an implementation partner who will then share the collected data with you.

Frequency of Collection: In this column, list the frequency in which this data needs to be collected. Time periods might be daily, weekly, monthly, quarterly, annually, etc. Time periods might also be dictated by certain events that occur. For example, data collection might always occur after a particular meeting or training event.

AFTER DATA COLLECTION

As you collect your data, share this data with your coalition leadership and Outreach and Education Specialist. Your Outreach and Education Specialist can assist in showing your subcommittee how you can use the data to address problems and barriers and measure success.

DATA COLLECTION WORKSHEET EXAMPLE

Metric	Instrument/Method	Collected From	Who Will Collect	Frequency of Collection
100% of steps in the implementation protocol are implemented as planned.	Protocol Tracking Sheet	Coalition Subcommittee and Partners	Emily Burton	Monthly
100% of participants achieve sufficient knowledge of how to implement care management and sustained follow-up care for individuals at risk of suicide.	Pre- and Post- Training Knowledge Tests Skill Proficiency Checklist	Training Participants	Training Coordinator	At each training
100% of healthcare organizations continue implementing care management and sustained follow-up care after the initial training and implementation period.				
100% of patients identified as being at risk for suicide receive care management services and sustained follow-up care services.				
80% of patients identified as needing suicide risk services or treatment obtain the appropriate level of treatment.				
Achieve the penetration benchmarks for Year 1, Year 2, Year 3, and Year 4.				

DATA COLLECTION WORKSHEET

Metric	Instrument/Method	Collected From	Who Will Collect	Frequency of Collection
100% of steps in the implementation protocol are implemented as planned.				
100% of participants achieve sufficient knowledge of how to implement care management and sustained follow-up care for individuals at risk of suicide.				
100% of healthcare organizations continue implementing care management and sustained follow-up care after the initial training and implementation period.				
100% of patients identified as being at risk for suicide receive care management services and sustained follow-up care services.				
80% of patients identified as needing suicide risk services or treatment obtain the appropriate level of treatment.				
Achieve the penetration benchmarks for Year 1, Year 2, Year 3, and Year 4.				